STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152027	A. BUILDING 00 B. WING	10/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF FORT WAYNE	2626 FAIRFIELD AVE FORT WAYNE, IN 46807

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S0000	The visit was for investigation of a licensure hospital complaint. Complaint Number: IN 00108917 Substantiated: Deficiencies cited related to the allegations. Date: 9-06, 9-07 and 10-02-12 Facility Number: 012132 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor QA: claughlin 12/14/12	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and interview, the chief executive officer failed to ensure that policies/procedures for all services were updated as needed for its nursing and medical records (MR) services. Findings: 1. On 10-02-12 at 0945 hours, staff A2 was requested to provide a policy/procedure regarding patient transfer to a higher level of care and none was provided prior to exit. 2. During an interview on 10-02-12 at 1535 hours, staff A4 confirmed that no transfer policy/standard of care was available regarding patient transfers to a higher level of care. 3. On 10-02-12 at 0945 hours, staff A2 was requested to provide a policy/procedure assuring that all MR entries shall be complete and shall be authenticated and dated in a timely manner and none was provided prior to exit. 4. During an interview on 10-02-12 at 1500	S0322	**Correction:** · Policy developed to address patient discharge o submittal of policy through next scheduled Quality, MEC, GB meetings · Policy developed to address requirements for all medical record entries to be authenticated, dated timely o submittal of policy through next scheduled Quality, MEC, GB meetings **Prevention:** · Staff in-service on new policies **Responsible Party:** Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Director Medical Records (DMR)	01/18/2013

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	hours, staff A2 and A4 confirmed that the policy/procedure Medical Record Content #6073 lacked the requirements and confirmed that the policy/procedure was the standard of care for nursing staff regarding MR documentation.			

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S0744	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based upon document review and interview, the facility failed to ensure all medical record (MR) entries were complete for 4 of 8 records reviewed (patient #'s 23, 26, 27 and 30) Findings: 1. The transfer documentation for patient 23 failed to indicate a signature, date and time by the responsible nurse completing the entry. 2. During an interview on 10-02-12 at 1545 hours, staff A3 confirmed that the transfer record for patient 23 lacked authentication by the responsible nurse. 3. The MR for patients 26 and 27 lacked documentation titled 'Communication For Other Facility ' completed on transfer by the responsible nurse and observed in the MR for patients 22, 23, 24, 25, 28 and 30. 4. During an interview on 10-02-12 at 1545 hours, staff A3 confirmed that the document was required and confirmed that the MR for patients 26 and 27 lacked the indicated documentation. 5. The MR nurses notes and transfer record for patient 30 lacked documentation that report was called to the receiving facility. 6. During an interview on 9-06-12 at 1550 hours, staff A4 confirmed that the MR documentation for	S0744	**Correction:** · Policy developed to address patient discharge including handoff report process o submittal of policy through next scheduled Quality, MEC, GB meetings · Policy developed to address requirements for all medical record entries to be authenticated and dated timely o submittal of policy through next scheduled Quality, MEC, GB meetings · Director of Quality Management (DQM) or designee to inform clinical staff of documentation non-compliance including transfer form as appropriate · CCO to enforce compliance per policy **Prevention:** · Staff in-service on new policies · Daily review of documentation for 30 days and monthly thereafter until compliance target achieved and maintained **Responsible Party:** DQM, CCO	01/18/2013

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	patient 30 failed to indicate that report was called to the receiving facility.			

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S0748	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3) (e) All entries in the medical record shall be: (3) authenticated and dated promptly in accordance with subsection (c)(3). Based upon document review and interview, the facility failed to ensure all entries in the medical record (MR) were authenticated and dated promptly for 4 of 8 records reviewed (patient #'s 23, 25, 26 and 30). Findings: 1. The MR documentation for patient 23 titled 'Communication For Other Facility ' lacked a signature and date by the responsible nurse completing the entry. 2. During an interview on 10-02-12 at 1545, staff A3 confirmed that the transfer record for patient 23 lacked a signature and date by the responsible nurse. 3. The policy/procedure Admission of a Patient (revised 3-11) indicated the following: " The Admission and Assessment Record must be completed by the nurse admitting within four (4) hours of admission. It may be signed by an LVN and cosigned by an RN. " 4. The nursing Admission Assessment for patients 23 and 30 lacked a signature, date and time when completed to validate compliance with the admission policy/procedure and the nursing Admission Assessment for patients 25 and 26 lacked a date and time when authenticated by the nurse.	S0748	**Correction:** · Policy developed to address requirements for all medical record entries, including nursing documentation to be authenticated and dated timely o submittal of policy through next scheduled Quality, MEC, GB meetings · Director of Quality Management (DQM) or designee to inform clinical staff of documentation non-compliance · CCO to enforce compliance per policy **Prevention:** · Staff in-service on new policies · Daily review of documentation for 30 days and monthly thereafter until compliance target achieved and maintained **Responsible Party:** DQM, CCO	01/18/2013

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	5. During an interview on 10-02-12 at 1550 hours, staff A3 confirmed that the medical records lacked the indicated documentation by nursing staff.			

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S0930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based upon document review and interview, the registered nurse failed to ensure that patient care was provided, evaluated and documented in accordance with physician orders for 4 of 8 medical records (MR) reviewed. Findings: 1. The policy/procedure Medical Record Content #6073 (revised 4-11) indicated the following: "Nurses notes and entries by non-physicians contain pertinent and meaningful information and observations. This information is documented on the respective forms as approved by the Medical Records Committee." 2. The MR for patient 22 lacked documentation by nursing staff indicating the patient was assisted out of bed related to the physician activity order Out of Bed with assistance for 23 of 29 days. 3. The MR for patient 24 lacked documentation by nursing staff indicating the patient was assisted out of bed related to the physician activity order Out of Bed with assistance/Up in Chair for 16 of 17 days. 4. The MR for patient 25 lacked documentation by nursing staff indicating the patient was assisted out of bed related to the physician activity order Out of Bed with assistance for 8 of 9 days.	S0930	**Correction:** · Director of Quality Management (DQM) or designee to inform clinical staff of documentation non-compliance · CCO to enforce compliance per standard **Prevention:** · Staff in-service on documentation requirements including daily activity of patient · Daily review of documentation for 30 days and monthly thereafter until compliance target achieved and maintained**Responsible Party:** DQM, CCO	01/18/2013

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	5. The MR for patient 30 lacked documentation by nursing staff indicating the patient was assisted out of bed related to the physician activity order Up in Chair for 13 of 19 days. 6. During an interview on 10-02-12 at 1545 hours, staff A3 confirmed that the medical records lacked the indicated documentation by nursing staff.			

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S0932	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. Based upon document review, medical record review and interview, the nursing staff failed to develop , utilize, and maintain an individualized plan of care for 5 of 9 medical records (MR) reviewed. 1. The policy/procedure Care Plans (revised 1-11) indicated the following: " A care plan will be developed on every patient ...within 24 hours [by] the RN ...The Care Plan will address the major medical problems and the rehabilitation potential of the patient ...The Care Plan will be updated once a week and as the patient condition changes ...It is extremely important that Care Plans are updated to show the patient ' s response to the treatment rendered. " 2. The Nursing Care Plan (NCP) for patient 22 lacked a standard of care addressing activity (Alteration in mobility) related to the physician activity order Out of Bed with assistance for the 3-27-12 admission. 3. The MR for patient 23 lacked a Nursing Care Plan for the patient. 4. The NCP for patient 25 lacked a standard of care addressing activity (Alteration in mobility) related to the physician activity order Out of Bed with assistance.	S0932	**Correction:** · Director of Quality Management (DQM) or designee to inform clinical staff of documentation non-compliance · CCO to enforce compliance per standard **Prevention:** · Staff in-service on documentation requirements including updating nursing care plan based on standards of care for each patient · Daily review of documentation for 30 days and monthly thereafter until compliance target achieved and maintained **Responsible Party:** DQM, CCO	01/18/2013

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	5. The NCP for patient 31 lacked a standard of care addressing activity (Alteration in mobility) related to the physician activity order Up to Chair. 6. The NCP for patient 30 failed to indicate a mobility goal related to the physician activity order Up in Chair. The NCP failed to indicate a standard of care for alteration in fluid volume/alteration in renal function related to the 30 pound weight gain and renal consult during the 19 day hospitalization. 7. During an interview on 10-02-12 at 1250 hours, staff A17 indicated that nursing orientation included instructions to record the ordered activity for each patient on the NCP standard of care Alteration in Mobility section under Goals. 8. During an interview on 10-02-12 at 1400 hours, staff A4 confirmed that the Care Plans lacked the indicated standards of care. Staff A4 confirmed that the NCP for patient 30 failed to indicate a mobility goal related to the physician activity orders and indicated that the Care Plan lacked a category for nursing staff to document a mobility intervention in addition to selecting a preprinted Plan response.			